IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 28, 2010

Brian Nall, Administrator
Benewah Community Hospital
229 South 7th Street
Saint Maries, Idaho 83861

RE: Benewah Community Hospital, Provider ID# 131317

Dear Mr. Nall:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Benewah Community Hospital, on April 20, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 11, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208) 334-6626.

Sincerely,

TOM MROZ
Health Facility Surveyor
Facility Fire Safety and Construction Program

TM/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131317	A. BUILDING 02 B. WING _____	04/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEWAH COMMUNITY HOSPITAL	**229 SOUTH 7TH STREET ST. MARIES, ID 83861**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The hospital is a single story structure with a partial finished basement that was originally constructed in 1958 with major additions and remodeling completed in 1997 and 2004. Basic construction type is V(111) except the 1997 addition which is Type II construction. The building is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for a light hazard occupancy. The building's fire alarm system was upgraded as part of the 2004 Surgical/OB addition/remodel. The following deficiencies were cited at the above facility during a validation survey conducted on April 20, 2010. The facility was surveyed under the Life Safety Code, 2000 Edition, Existing Health Care Occupancies in accordance with 42 CFR 282.41(b) The fire/life safety survey was conducted by: Tom Mroz CFI-II Facility Fire Safety & Construction Bureau of Facility Standards Idaho Department of Health & Welfare	K 000	RECEIVED MAY 10 2010 FACILITY STANDARDS	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Vall — TITLE: CEO — (X6) DATE: 5/6/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based on observation the facility failed to maintain the integrity of the utility room northwest ceiling smoke barrier. The deficient practice would affect 1 of 12 smoke compartments Findings include: During observation of the utility room northwest ceiling smoke barrier on April 20, 2010 between 1:00 p.m. and 5:00 p.m., the facility failed to maintain the integrity of the ceiling smoke barrier. A 10 " by 10 " open ceiling penetration was observed in utility room northwest. The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: §8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. §8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 025	Installed fire proof access door.	4/30/10

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K 025	Continued From page 2 b. It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that corridor smoke doors closed shut. The deficient practice would affect residents, staff and the public in two of four smoke compartments in the facility. Findings include: During observation on April 20, 2010 between 1:00 p.m. and 5:00 p.m., it was observed the basement corridor smoke doors between the mechanical room and the fire panel room would not close shut upon release of the magnetic hold-open device. Interview with the facility Maintenance Supervisor on April 20, 2010 between 1:00 p.m. and 5:00 p.m., indicated the facility was not aware the door would not close shut.	K 027	Adjusted doors for proper closing.	4/28/10

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K 027	Continued From page 3 The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: NFPA 101 §19.376 Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel.	K 027		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation it was determined that the facility had not ensured a smoke resisting self-closing door were installed and operational in hazardous locations. Findings include: 1.) Observation made on April 20, 2010 between	K 029		

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K 029	Continued From page 4 1:00 p.m. and 5:00 p.m.disclosed that the existing door to the main electric breaker panel room was propped open. Lack of closed doors potentially allows hot gases and smoke to penetrate throughout the smoke compartment in the event of a fire emergency. The observations were observed mutually by Maintenance Supervisorand surveyor. 2.) Observation made on April 20, 2010 between 1:00 p.m. and 5:00 p.m.disclosed that the existing door to the laundry room was propped open. Lack of closed doors potentially allows hot gases and smoke to penetrate throughout the smoke compartment in the event of a fire emergency. The observations were observed mutually by Maintenance Director #1 and surveyor. The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA Standard: NFPA 101 §19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with §8.4.1. The automatic extinguishing shall be permitted to be in accordance with §19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing.	K 029	Relocating freezers and closing doors to the mechanical and electrical rooms. Staff informed to keep door closed.	5/21/10 5/6/10
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 5 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review, the facility failed to document fire drills were being performed once per shift per quarter. The deficient practice would affect all staff and all residents within the facility. Findings include: During record review of the facility fire drill records on April 20, 2010 at 2:05 p.m., the facility was unable to provide documentation of fire drills for the 3rd and 4th quarter nocturnal shift in 2009. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: NFPA 101 §19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are	K 050	Work order has been generated on fire drills for July day and night.	7/30/10 7/13/10 term completed Drill per fax

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K 050	Continued From page 6 conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This Standard is not met as evidenced by:	K 051		

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K 051	Continued From page 7 Based on observation the facility failed to provide a smoke detector above the fire alarm control panel power supply/auxilliary unit. The deficient practice would affect all smoke compartments, all residents, visitors and staff of the facility. Findings include: Observation of the fire alarm control panel room on April 20, 2010 between 1:00 p.m. and 5:00 p.m. the facility failed to provide automatic smoke detection at the fire alarm control panel. Lack of smoke detection may cause the fire alarm control panel to be incapacitated by fire before a detection device responded. Interview with the facility Maintenance Supervisor on April 20, 2010 between 1:00 p.m. and 5:00 p.m., indicated the facility was not aware that smoke detection was required at this location. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: NFPA 72 § 1-5.6 Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location.	K 051	Waiting for scheduling from SimplexGrinnell.	7/30/10
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052		

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K 052	Continued From page 8 requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on interview and record review, the facility failed to ensure the fire alarm system was in compliance with the provisions of NFPA 72 National Fire Alarm Code 1999 Edition. The deficient practice would affect all residents, visitors and staff in all compartments. Findings include: 1.) During review of the facility's fire alarm system testing records on April 20, 2010 at 1:30 p.m., the firm that performed the annual inspection on April 14, 2010 noted on the inspection report that the pull station in the 7th Street lobby was not working. Interview with the facility Maintenance Supervisor on April 20, 2010 at 1:30 p.m indicated the facility has scheduled for the repair to be performed by the inspection firm. 2.) During review of the facility's fire alarm system testing records on April 20, 2010 at 1:35 p.m, the firm that performed the annual inspection on April 14, 2010 noted on the inspection report that the audio visual device in the corridor by the laboratory double doors was inoperative. Interview with the facility Maintenance Supervisor on April 20, 2010 at 1:30 p.m indicated the facility has scheduled for the repair to be performed by the inspection firm.	K 052	Contracting with SimplexGrinnell to repair pull station. Contracting with SimplexGrinnell to repair audio-visual device.	6/30/10 6/30/10

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K 052	Continued From page 9 The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard(s): Item #1: NFPA 72, § 2-6.2 Initiation of the alarm signal shall occur within 90 seconds of waterflow at the alarm-initiating device when flow occurs that is equal to or greater than that from a single sprinkler of the smallest orifice size installed in the system. Movement of water due to waste, surges, or variable pressure shall not be indicated.	K 052		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that all smoke detectors had received necessary maintenance to assure adequate sensitivity. The census was 4 on the day of the survey. The findings include: Record review on April 20, 2010 at 1:45 p.m. disclosed that the facility records did not show that sensitivity testing of smoke detectors had been conducted throughout the building for new installations.	K 054	Contracted with SimplexGrinnell for 7/2/10. Report to follow. 7/2/10 per fax tests complete	

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K 054	Continued From page 10 The facility was unable to provide documentation of any current or complete sensitivity testing of smoke detectors. There was no written record of test cycles by the fire alarm contractor; no documentation or reports of status of the system detectors was available for review. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010 . Actual NFPA standard: NFPA 72, section 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054		
K 056	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056		

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K 056	Continued From page 11 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation the facility did not ensure that the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. These deficient areas would not have the ability to slow fire growth and provide more time for the residents to evacuate should a fire start in one of these non-sprinklered areas. The deficient practice would affect all residents, visitors and staff in two of twelve smoke compartments. Findings include: 1.) During the facility tour on April 20 2010 between 1:00 p.m. and 5:00 p.m. observation of the 7th Street entrance vestibule indicated did not have any sprinkler protection in place. The covered entry way measures approximately twelve feet by twelve feet in size. This was observed by the surveyor and the maintenance supervisor. This deficiency affected staff and vistors in one of twelve smoke compartments. 2.) During the facility tour on April 20 2010 between 1:00 p.m. and 5:00 p.m. observation of the penthouse mechanical room corridor indicated did not have any sprinkler protection in place. The corridor measures approximately four feet by twenty feet in size. This was observed by	K 056	Space scheduled for demolition. Contracted with Western States waiting for schedule.	~~8/31/10~~ 9/1/10 per e-mail 7/30/10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 12 the surveyor and the maintenance supervisor. This deficiency affected staff in one of two smoke compartments. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on April 20 2010. Actual NFPA Standard: NFPA 13 §1-6.1 A building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas.	K 056		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that portable fire extinguishers were in accordance with NFPA 10 requirements. The deficient practice would affect all employees within the kitchen. Findings include: 1.) Observation on April 20, 2010 between 1:00 p.m. and 5:00 p.m. revealed that the portable fire extinguisher in the kitchen was on the floor. The	K 064	Installed wall bracket and hung portable fire extenguisher.	4/28/10

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K 064	Continued From page 13 deficient practice would affect all employees within the kitchen. 2.) Observation on April 20, 2010 between 1:00 p.m. and 5:00 p.m. revealed that the portable fire extinguisher in the wall mounted cabinet in the corridor outside of the laboratory was obstructed by a table and obscured from view by a large plant. The deficient practice would affect anyone attempting to locate a fire extinguisher in the vicinity of the laboratory. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: Item #1) NFPA 96, §10.10 Portable Fire Extinguishers. Portable fire extinguishers shall be installed in kitchen cooking areas in accordance with NFPA 10, Standard for Portable Fire Extinguishers, and shall be specifically listed for such use. NFPA 10 Fire Extinguishers §1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas.. §1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). Item #2) NFPA 10 Fire Extinguishers	K 064	Removed plant and table.	5/6/10

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K 064	Continued From page 14 §1-6.6 Fire extinguishers shall not be obstructed or obscured from view.	K 064		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the cooking operation was in compliance with the provisions of NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. The deficient practice would affect the kitchen compartment and staff within the kitchen compartment. Findings include: 1.) Review of the facility's commercial cooking equipment fire suppression system testing records on April 20, 2010 at 2:25 p.m. revealed that the kitchen hood system had not been inspected since 2008. Interview with the facility Maintenance Supervisor on April 20, 2010 indicated the facility was not aware that the system was past due for inspection. 2.) Observation on April 20, 2010 at 3:25 p.m. revealed that the kitchen hood grease removal filters are mesh type filters. This type of filter is not tested, listed or acceptable for commercial cooking operations. Maintenance Supervisor on April 20, 2010 at 3:25 p.m. indicated the facility was not aware that mesh type filters were prohibited.	K 069	Oxarc inspected system. Replacing with compliant filters.	4/21/10 6/30/10

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K 069	Continued From page 15 The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard(s): NFPA 96, Item #1)§11.2 Inspection of Fire-Extinguishing Systems §11.2.1 An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. Item #2)§6.1 Grease Removal Devices. §6.1.1 Listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. §6.1.2 Listed grease filters shall be tested in accordance with UL 1046, Standard for Grease Filters for Exhaust Ducts. §6.1.3 Mesh filters shall not be used. §3.3.22.2* Mesh-Type Filter. A general purpose air filter not listed for or intended for grease applications.	K 069		
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

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K 072	Continued From page 16 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured a complete and clear path through corridors serving as exit access for one of twelve corridors sampled. The findings include: Observation during tour of the building on April 20, 2010 between 1:00 p.m. and 5:00 p.m., disclosed the corridor by room 109 was obstructed by approximately four wheelchairs. The observations were jointly observed by the surveyor and Maintenance Spervisor The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA 101 reference: 7.1.3.2.3* An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. (See also 7.2.2.5.3.)	K 072	Adjusting wheel chair storage to accommodate wheel chairs.	6/30/10
K 140	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This Standard is not met as evidenced by:	K 140		

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K 140	Continued From page 17 Based on interview and record review, the facility failed to ensure the medical gas system was in compliance with the provisions of NFPA 99 National Fire Alarm Code 1999 Edition. The deficient practice would affect all patients, visitors and staff in four of twelve compartments. Findings include: 1.) During review of the facility's medical gas verification/inspection inspection report on April 20, 2010 between 1 p.m. and 5 p.m., the firm that performed the inspection on April 6, 2010 noted on the inspection report that there was no high-low alarm for the medical air. Interview with the facility Maintenance Supervisor on April 20, 2010 between 1 p.m. and 5 p.m., indicated the facility was not aware there was no high-low alarm for the medical air. 2.) During review of the facility's medical gas verification/inspection inspection report on April 20, 2010 between 1 p.m. and 5 p.m., the firm that performed the inspection on April 6, 2010 noted on the inspection report that there was no emergency level low alarm. Interview with the facility Maintenance Supervisor on April 20, 2010 between 1 p.m. and 5 p.m., indicated the facility was not aware there was no emergency level low alarm for the medical air. 3.) During review of the facility's medical gas verification/inspection inspection report on April 20, 2010 between 1 p.m. and 5 p.m., the firm that performed the inspection on April 6, 2010 noted on the inspection report that the emergency room doesn't have an area alarm. Interview with the facility Maintenance Supervisor on April 20, 2010 between 1 p.m. and 5 p.m., indicated the facility	K 140	Addition/renovation of new medical/surgical building will meet current code requirements for high-low alarm system. Addition/renovation of new medical/surgical building will meet current code requirements for high-low alarm system. Renovation of emergency room will meet current alarm code requirements.	12/2011 12/2011 12/2011

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K 140	Continued From page 18 was not aware that the emergency room doesn't have an area alarm. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010.	K 140		
K 141	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This Standard is not met as evidenced by: Based on observation and interview the facility failed to post "No Smoking" signage in areas where oxygen is stored. Findings include: During observation of the medical gas storage room on April 20, 2010 between 1 p.m. and 5 p.m., the facility failed ensure no smoking signs were posted on the exterior entrance door to the medical gas storage room. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010. Actual NFPA standard: NFPA 99, §8-6.2.5 Gases in Cylinders and Liquefied Gases in Containers. §8-6.4.2 Signs. Precautionary signs, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in	K 141	Installed No Smoking sign.	4/27/10

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K 141	Continued From page 19 aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means. §8-3.1.11 Storage Requirements8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:	K 141		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure clearance around electric circuit breaker(s) was maintained. The deficient practice would affect patients, staff and visitors in one of twelve smoke compartments. Findings include: During observation of the 8th Street electric utility room on April 20, 2010 between 1:00 p.m. and 5:00 PM, the facility failed to ensure that storage was not permitted in front of electric breaker panels. Interview with the facility Maintenance Supervisor on April 20, 2010, indicated the facility was aware that storage obstructing breaker panels was not permitted. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010.	K 147	Removed excess storage from area and marked off a no storage zone.	4/28/10

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K 147	Continued From page 20 Actual NFPA standard: NFPA 70 §110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.	K 147		

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B 000	16.03.14 Initial Comments The hospital is a single story structure with a partial finished basement that was originally constructed in 1958 with major additions and remodeling completed in 1997 and 2004. Basic construction type is V(111) except the 1997 addition which is Type II construction. The building is protected throughout by an automatic fire extinguishing system design/installed per NFPA Std 13 for a light hazard occupancy. The building's fire alarm system was upgraded as part of the 2004 Surgical/OB addition/remodel. The following deficiencies were cited at the above facility during a validation survey conducted on April 20, 2010. The facility was surveyed under IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho The fire/life safety survey was conducted by: Tom Mroz CFI-II Facility Fire Safety & Construction Bureau of Facility Standards Idaho Department of Health & Welfare	B 000	RECEIVED MAY 10 2010 FACILITY STANDARDS	
BB163	16.03.14.510.03 Electrical Safety A continued effort shall be made to provide an electrically safe environment within the hospital. Written policies and procedures shall be established for, but not limited to, the following: Methods and frequency of testing, verification of performance, and use specifications for all hospital electrical patient care equipment. All new equipment shall be tested prior to use and in no case shall the retesting interval exceed one (1) year; and Periodic evaluation of the electrical distribution system and all nonpatient care equipment.	BB163		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Noll — TITLE: CEO — (X6) DATE: 5/6/10

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BB163	Continued From Page 1 Inspection and testing of nonclinical equipment shall be performed at regular intervals to be determined by the chief maintenance engineer; and Specific restrictions on the use of extension cords and adapters. Extension cords shall be used in emergency situations only, be of the grounded type and have wire gauge compatible to the piece of equipment being used; and Prohibition of the use of personal electrical equipment by patients and employees. Specific items may be allowed if the hospital adopts formal policies for defining and inspecting them. This Rule is not met as evidenced by: Based on observation, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code and State codes applicable to hospitals. Findings include: During observation of the records storage room on April 20, 2010 between 1:00 p.m. and 5:00 p.m., the facility utilized and extension cord to power an unknown device. The extension cord was run from an wall outlet in the closet, up the wall and into the ceiling space. Extension cords have the potential to heat up and ignite resulting in a fire causing injury to the staff and property damage to the facility. Interview with the facility Maintenance Supervisor on April 20, 2010, indicated the facility was not aware of the extension cord being utilized. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010 .	BB163	Removed extension cord, replaced with hard wired outlet	4/29/10

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BB502	Continued From Page 2	BB502		
BB502	16.03.14.510.04 Smoking 04. Smoking. Because smoking has been acknowledged to be a fire hazard, a continuous effort shall be made to reduce its presence in the hospital. Written regulations governing smoking shall be conspicuously posted and made known to all hospital personnel, patients, and the public. These regulations shall include provisions for compliance with the "Idaho Clean Indoor Air Act" and at least the following provisions: (10-14-88) a. Smoking shall be prohibited in any area of the hospital where flammable liquids, gases or oxygen is in use or stored. These areas shall be posted with appropriate signage; and (10-14-88) b. Patients shall not be permitted to smoke in bed unless a responsible person is in attendance; and (10-14-88) c. Unsupervised smoking by patients classified as not mentally or physically responsible shall be prohibited. This shall also include patients so affected by medications; and (10-14-88) d. Smoking shall be prohibited in areas where combustible materials and supplies are stored; and (10-14-88) e. Designated areas shall be provided for employee and visitor smoking. This requirement need not be complied with in any hospital that has established, by policy, that smoking is prohibited within the hospital. (10-14-88) This Rule is not met as evidenced by:	BB502		

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BB502	Continued From Page 3 Based on observation the facility failed to prohibit smoking in any area of the hospital where flammable liquids, gases or oxygen is in use or stored. The deficient practice would affect all residents, staff and visitors. Findings include: During observation of the employee smoking area on April 20, 2010 between 1:00 p.m. and 5:00 p.m. a hospital employee was observed smoking within 15 feet of the door to the flammable gas storage room. Smoking near flammable liquids, gases or oxygen has the potential to ignite the material and cause harm to staff, patients and visitors. This was observed by the Maintenance Supervisor and the surveyor. The findings were acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010 .	BB502	Smoking area is closed.	5/21/10
BB516	16.03.14.520.02 Drills 02. Drills. The plan shall be rehearsed annually. (10-14-88) This Rule is not met as evidenced by: Based on interview and record review on April 20, 2010 between 1:00 p.m. and 5:00 p.m., it was determined the facility failed to conduct an annual external disaster drill. Failure to perform an annual disaster plan drill has could result in the potential for the facility ' s inability to effectively deal with the care, health and safety of patients, staff and other individuals when a major disruptive event occurs. Findings include: The facility ' s emergency preparedness plan,	BB516		

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BB516	Continued From Page 4 undated, was reviewed. There was no record of an emergency preparedness drill being conducted annually to test the plan ' s effectiveness. When asked about the plan, on April 20, 2010 between 1:00 p.m. and 5:00 p.m, the facility ' s Maintenance Supervisor acknowledged the lack of an annual drill. The finding was acknowledged by the Chief Executive Officer and verified by the Maintenance Supervisor at the exit interview on April 20, 2010.	BB516	Participated in Highland Springs Exercise on July 15 and Aug. 19 2009. Also participated in Emergency Operations Plan exercise on Dec. 1, 2009. Attachment A.	5/6/10